

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039476

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 246

FILED NOV 13 1963

1. PLACE OF DEATH a. COUNTY <u>Franklin County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		Length of stay in 1b <u>One week</u>	c. CITY OR TOWN <u>Hermann</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>428 West 8</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Peter J. Jacquin</u>			4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1885</u>	9. AGE (last birthday) <u>78</u>	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Morrison, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>United States</u>		13a. FATHER'S NAME <u>Pierre Jacquin</u>		13b. MOTHER'S MAIDEN NAME <u>Augustine Bruelle</u>	
14. NAME OF HUSBAND OR WIFE <u>Louise Jacquin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Ray Jacquin</u>		18. ADDRESS <u>Hermann Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month _____ Day _____ Year _____		
20d. INJURY OCCURRED - WHILE AT WORK <input type="checkbox"/> - NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <u>8-17-47</u> to <u>11-10-63</u> and last saw her/him alive on <u>11-10-63</u> Death occurred at <u>4:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George M. Workman M.D.</u>		22b. ADDRESS <u>Hermann, Missouri</u>	22c. DATE SIGNED <u>11-11-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/13/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Geo Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hermann Missouri</u>
24. FUNERAL DIRECTOR <u>Leon Toedtman Hermann, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11/17/63</u>	26. REGISTRAR'S SIGNATURE <u>Leola C. Hudmann</u>

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leon Tocottmann

Licensed Embalmer No. 5202

P. O. Address Hermann, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.